



TEXAS DEPARTMENT OF HEALTH **TEXAS HEALTH STEPS (THSTEPS) MEDICAL CASE MANAGEMENT** **PROVIDER APPLICATION**

SECTION 1

Provider Name:		Address:	
City:		County:	
			Zip:
Phone Number:		Fax Number:	
		E-Mail Address:	
TDH Region:		Case Management Director/Coordinator & Title:	
Funding Type Entity:			
Public:	Private (Nonprofit):	Private (For Profit):	*FQHC :

(Public Providers are those that are owned or operated by state, county, city, or other local government agency or instrumentality. All other entities are considered to be private providers.)

*(Federally Qualified Health Centers)

Describe your agency and current services provided:

SECTION 2

If your THSteps MCM client needs assistance with any of the following issues, where would you refer them in the communities (counties) you are applying to serve? Please include the agency name, address, telephone number, and a contact person. Each community (county) needs to be addressed individually. Indicate in the appropriate column if you currently provide this service or make referrals and for what length of time. *Letters of support are required from primary, preventive and tertiary referral sources and are indicated with an asterisk.

For Example:

If the client needs emergency shelter

Name: Safe Place
Address: 100 Main Street
Timbuktu, Texas
Phone: 512-333-4444
Contact: Mary Poppins

County of:

Advocating for Special Needs at School			Referred Provided Length of Time
Durable Medical Equipment/Supplies, i.e., Wheelchair, Diapers, Feeding Tubes			Referred Provided Length of Time
Medically Dependent Children Program (MDCP)			Referred Provided Length of Time
Community-Based Alternatives (CBA)			Referred Provided Length of Time
In-Home & Family Support (IHFS)			Referred Provided Length of Time

Community Living Assistance & Support Services (CLASS)			Referred Provided Length of Time
Home & Community Services (HCS)			Referred Provided Length of Time

Children With Special Health Care Needs (CSHCN)			Referred Provided Length of Time
Family Planning			Referred Provided Length of Time
Prenatal Health Care Services			Referred Provided Length of Time
Utility Assistance			Referred Provided Length of Time
Emergency Food Assistance			Referred Provided Length of Time
Mental Health			Referred Provided Length of Time
Substance Abuse			Referred Provided Length of Time

Emergency Shelter			Referred Provided Length of Time
Transportation Services (Community Resources & Medicaid Transportation)			Referred Provided Length of Time
*Locating a Doctor/ Dentist on Medicaid (THSteps O&I)			Referred Provided Length of Time
Nutritional Services (WIC)			Referred Provided Length of Time
Occupational, Physical & Speech Therapy Rehabilitative Services			Referred Provided Length of Time
Respite Care/ Attendant Care			Referred Provided Length of Time
*Acute/Hospital Care			Referred Provided Length of Time

Early Childhood Intervention			Referred Provided Length of Time
Targeted Case Management for Pregnant Women & Infants			Referred Provided Length of Time
Targeted Case Management for MHMR			Referred Provided Length of Time
Targeted Case Management for the Blind & Visionally Impaired			Referred Provided Length of Time
Resources for Migrant Workers & their Families			Referred Provided Length of Time

SECTION 3

List all counties in which you propose to provide THSteps Medical Case Management services. If area is less than a whole county, zip codes must be listed:

Identify any limitations to the population you/your agency serves. For example, if you do not serve anyone over twelve (12) years of age, please note. Limitations must apply to all populations and not be specific to the Medicaid population.

List all counties in which you propose to provide THSteps Medical Case Management services. If area is less than a whole county, zip codes must be listed:

SECTION 4

***Please read the THSteps Medical Case Management rules carefully before completing this section. Please number your responses to each statement below. (Add additional pages as necessary.)**

- (1) Describe your comprehensive case management program; include all components.
- (2) Describe how clients may be referred to THSteps Medical Case Management services.
- (3) Describe how you will address the home visit program requirement.
- (4) Will you be using community service aides and if so how?
- (5) Describe your agency plan for continuity of care, i.e., termination of services; eligibility issues; transfer of services, etc.
- (6) Describe how your agency participates in collaborations, networking meetings, education and outreach activities which promote THSteps Medical Case Management in your community.
- (7) Describe how you will demonstrate your coordination with other community-based case management programs.
- (8) Describe how you/your agency will act as advocates on behalf of THSteps Medical Case Management clients and empower clients to access services independently.
- (9) If you/your agency is a provider of other services reimbursed by Medicaid and/or TDH through contract, fee for service or in a capitated rate, i.e., discharge planning from an institution, care coordination by a STAR (Medicaid Managed Care) provider, etc., please list and describe how you will distinguish those services from THSteps Medical Case Management services. In addition, how will you/your agency insure nonduplicative billing/reimbursement?
- (10) How will you/your agency insure that clients/families are aware of their freedom to choose among all existing case management providers?
- (11) Describe the resource directories you utilize in the various communities (counties) served.

SECTION 5

The agency will have a Case Management Quality Assurance plan. THSteps Medical Case Management must be integrated into the agency's Quality Assurance Program/Evaluation Plan. (Use additional pages as necessary.)

- (1) Describe your THSteps Medical Case Management program evaluation process. The following components must be included:
 - C Quarterly record review (not less than 10% of charts).
 - C If a small agency, seeing less than 25 clients, a representative sample is necessary, i.e., three to five charts in this example.
 - C Annual direct observation of staff/client interactions.
 - C Client satisfaction surveys of all closed/transferred cases.
 - C Annual satisfaction surveys of PCPs and case managers.
- (2) Identify the staff positions who will participate in evaluation activities.
- (3) State how the findings from the quality assurance/satisfaction summaries and observation evaluation will be used in planning and/or improving existing program services and systems.

SECTION 5

SECTION 6

Document the number of case management staff who meet the definition of “case manager” in the program rules and who are eligible to bill Medicaid for reimbursement. Record in “full-time equivalents” (FTEs) the amount of time they will devote to THSteps Medical Case Management activities. (For example, two staff each working 20 hours dedicated to THSteps MCM would equal one FTE.)

Registered Nurses		Social Workers	
Total #	FTE	Total #	FTE

Please attach résumés and copies of licenses.

Document the other personnel who will be performing activities related to THSteps Medical Case Management. Record in FTEs, the amount of time they will devote to case management. Do not include the RN/SW case managers here

Community Service Aides		Other (Describe)	
Total #	FTE	Total #	FTE

Anticipated monthly unduplicated number of new admissions - the number of new client intakes an agency can complete for THSteps Medical Case Management services in any given month.

Anticipated monthly total caseload for case management services - the total number of active clients for which an agency can provide THSteps Medical Case Management services at any given point in time.

SECTION 7

Provider Assurances:

If approved as a THSteps Medical Case Management provider, the applicant certifies that they will:

1. Provide case management services in a manner consistent with the Rules, Policies and Procedures for THSteps Medical Case Management, Guidelines for Case Management, Child Health, and CSHCN, and Medicaid rules
2. Participate in cost analysis studies of case management.
3. Comply with all Texas Department of Health (TDH) reporting requirements.
4. Submit to periodic monitoring and evaluation reviews by TDH.
5. Share individual patient information including appropriate releases of information, with other pertinent health, social and case management providers so that indicated referral and tracking may occur.
6. Assure TDH that advocacy will be a primary role in service provided and no conflict of interest exist. Assure that clients are given freedom of choice in all provider decisions.
7. Employ registered nurses and licensed social workers, as Medicaid case managers, who meet all of the case manager requirements as detailed in the TDH THSteps Medical Case Management Rules. The applicant further certifies that each case manager will attend a TDH-approved case management orientation/education program prior to billing.

Case Management Program Director

Date

Agency Director

Date

SECTION 8

_____ ☐ **Approve** ☐ **Disapprove**
Regional Director of Social Work Date

Regional Office Comments:

Central Office Review Staff: ☐ **Approve** ☐ **Disapprove**

_____ Date

_____ Date
Division Director

Comments: